

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE **HEALTH AFFAIRS**

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PDR

CHANGE NO. 119 OCHAMPUS 6010.49-M August 7, 1998

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL **FOR OPERATIONS MANUAL**

THE DIRECTOR, OCHAMPUS, HAS AUTHORIZED THE FOLLOWING CHANGE(S) TO OCHAMPUS **MANUAL 6010.49-M, REISSUED JULY 1992:**

PAGE CHANGE(S):

PART TWO:

Chapter 1

PART THREE: Chapters 1 and 4

REMOVE AND INSERT PAGE(S): (See page 2 of this transmittal)

SUMMARY OF CHANGE(S): THIS CHANGE IMPLEMENTS PROVISIONS OF THE FEBRUARY 13 AND FEBRUARY 24, 1998, FINAL RULES. THE FEBRUARY 13 FINAL RULE PROTECTS PRIME ENROLLEES FROM BALANCE BILLING BY NON-PARTICIPATING PROVIDERS; THE FEBRUARY 24 FINAL RULE ELIMINATES THE INAS REQUIREMENT FOR OUTPATIENT MATERNITY CARE AND WAIVES THE PRIME ENROLLMENT FEE FOR CERTAIN BENEFICIARIES WHO ARE ELIGIBLE FOR BOTH TRICARE AND MEDICARE. THIS CHANGE IS ISSUED IN CONJUNCTION WITH POLICY MANUAL CHANGE NO. 29 AND ADP MANUAL CHANGE NO. 70.

EFFECTIVE DATE AND IMPLEMENTATION: THE EFFECTIVE DATE IS AS INDICATED ON THE ATTACHED PAGES, IMPLEMENTATION IS UPON DIRECTION OF THE CONTRACTING OFFICER.

Sheila H. Sparkman

Director, Program Development and Evaluation

ATTACHMENT(S): 13 PAGE(S)

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Claims Processing Procedures

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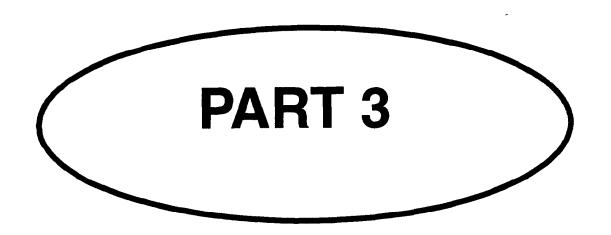
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30	Charges exceed monthly maximum.
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II. REFERRAL FUNCTIONS

The contractor, using Health Care Finders and PCMs, is responsible for coordinating referral functions for all Military Health System (MHS) beneficiaries. The TRICARE Prime program requires that specialty and *inpatient* services be accessed by enrollees only upon referral by a PCM and with authorization by the Health Care Finder or other contractor designee except in the case of medical emergencies, outpatient mental health services referenced in Section II.A.1.a.(1) of this section, *clinical preventive services* (Policy Manual Chapter 12, Section 8.1), and the use of the Point of Service option.

A. Health Care Finder

The contractor shall establish and maintain, in all areas with TRICARE Service Centers, Health Care Finder functions to facilitate referrals of beneficiaries to military and civilian health care services. The contractor shall provide a staff of Health Care Finders to ensure that referral services are available at all times through a TRICARE Service Center with no more than a fifteen (15) minute wait for beneficiaries visiting the TRICARE Service Center. The telephone blockage rate at each TRICARE Service Center shall not exceed five percent (5%), and beneficiaries telephoning the TRICARE Service Center shall never be placed on "hold" for more than five (5) minutes. Additionally, the contractor shall provide Health Care Finder services through a nationally accessible toll-free number. The contractor shall continuously staff all incoming toll-free Health Care Finder lines 24-hours per day, 7-days-a-week with qualified Health Care Finders. (See OPM Part Three, Chapter 4, Section VI.B. for toll-free line standards and requirements.) The toll-free line operation may be centralized in one or more locations.

1. Health Care Finder Functions

The Health Care Finders shall perform the following principal

functions:

a. Facilitate Referrals

The contractor shall establish referral mechanisms to ensure optimal utilization of MTF facilities and resources and to foster coordination of all care delivered in the civilian sector and care referred to and from the MTFs. The contractor shall contact the MTFs to determine capacity before recommending or authorizing care with civilian providers. The referral-facilitation services of the Health Care Finders are primarily for ensuring access to care for enrolled beneficiaries; however, nonenrolled beneficiaries are encouraged to use the Health Care Finder functions to find care in the network under TRICARE Extra. [(Nonenrollees are required to seek authorizations from the Health Care Finder prior to an NAS being issued (Section II.A.1.b. of this section)]. When space is not available in the MTFs, Medicare-eligible beneficiaries can use the Health Care Finder to access providers who accept Medicare assignment. Referrals shall be processed on CHCS (when required by contract).

(1) Referral to Primary Care

Enrolled beneficiaries must initially obtain *most health* care services from their *PCMs* or have their *claims* adjudicated in accordance with the Point of Service provisions (TRICARE/CHAMPUS Policy Manual, Chapter 12, Section 10.1). Enrollees may seek outpatient mental health services through their PCMs, or they may self-

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refer to a network mental health provider for the first eight (8) visits. In those cases where an enrollee self-refers, the contractor shall ensure that the network mental health provider obtains an authorization from the Health Care Finder for services rendered. This authorization is only to ensure that claims are processed appropriately and is not a prospective review as defined by OPM Part Three, Chapter 3, Section I. For all beneficiaries, outpatient mental health care beyond the eighth (8th) visit shall be prospectively reviewed for medical necessity. For nonenrolled beneficiaries who initially contact the Health Care Finder at the TRICARE Service Center or by telephone, the contractor shall maintain mechanisms to facilitate referrals to care. These mechanisms shall be made available to the Lead Agents. In catchment areas containing more than one MTF, the contractor shall, after consultation with the Lead Agents and the MTF Commanders and in accordance with DoD policy, establish mechanisms to ensure that: (1) all MTF resources in the area are considered before recommending or authorizing care with civilian providers (determinations on MTF referrals shall be subject to travel distances to the MTF where services are available for patients with consideration given to the nature of the medical problem); and (2) coordination is maintained among the respective TRICARE Service Centers. All network mental health providers shall agree to provide TRICARE Prime beneficiaries' PCMs with a report of the treatment rendered if the beneficiary authorizes the release of the information.

(2) Referral to Specialty and Inpatient Services

The contractor shall establish referral procedures to ensure access to specialty and *inpatient* health care services for all MHS-eligible beneficiaries, especially enrollees.

(a) The Health Care Finder shall assist the PCM in facilitating specialty and inpatient referrals for care available in the MTF or, if not available (or not available within a medically appropriate time period), to a provider within the contractor's network except in those cases where, for a Prime enrollee with an MTF PCM, the MTF has determined, after consultation with the contractor, that the care required could be provided more cost-effectively by a non-network provider.

within the medically appropriate time period from a provider in the contractor's network, the contractor shall arrange for care with a provider outside the contractor's provider network. Contractors shall apply Prime provisions to claims for referred and authorized care received by prime enrollees from non-network providers. Contractors shall ensure that referring network providers and Health Care Finders follow established referral/authorization procedures in order to avoid the inappropriate application of Point of Service cost-sharing to claims for referred/authorized care received by Prime enrollees from non-network providers.

Note:

Effective with care received on or after March 16, 1998, contractors shall allow the lesser of the billed charges or 115% of CMAC on claims for Prime enrollees receiving emergency or referred/authorized care from non-network, non-participating providers. Enrollees shall pay only the Prime copayment. Refer to Policy Manual Chapter 12, Section 2.1, for information on claims for certain ancillary services. Contractors need not review past claims for those processed under obsolete requirements. If, however, it is brought to a contractor's attention that a claim was processed according to previous

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requirements and the date of service is on or after March 16, 1998, the contractor shall adjust the claim according to the new requirements.

tenrollees receive care from network providers and shall authorize the use and services of each non-network provider involved in referred care including institutions that use consultants or other non-network providers. MTFs may refer their Prime enrollees to a non-network provider who is determined to be less costly or in instances where there are no clinically appropriate network providers. The Health Care Finder shall facilitate the referral. Referrals shall be processed on CHCS (when required by contract).

b. Authorizations

(1) For Prime enrollees, all specialty and inpatient medical care not provided by the PCM except emergencies, outpatient mental health services referenced in paragraph a(1) above, clinical preventive services supplied by network providers (TRICARE/CHAMPUS Policy Manual, Chapter 12, Section 8.1), and services obtained under the Point of Service option, must be referred from the PCM and authorized by the Health Care Finder or other contractor designee. This requirement is applicable for services referred to the MTF when the enrollee has been assigned a PCM in the network or for services referred to a provider outside the MTF when the enrollee has been assigned an MTF PCM.

NOTE:

Nonenrolled beneficiaries are not required to obtain authorization for care from the Health Care Finder except when an NAS is required. Providers serving nonenrollees shall comply with the prior authorization requirements established under OPM Part Three, Chapter 3, Section I.B.3.b.

(2) The Health Care Finder authorization functions shall include first level review of all referrals for medical necessity, for those admissions and procedures that require preauthorization, as outlined in OPM Part Three, Chapter 3 and Chapter 5. Also, the review will include the determination that care was referred from the PCM. In addition, MTF commanders may give Health Care Finders written authorization to perform the authorization functions for referrals from MTF PCMs to other MTF providers. MTFs that desire contractor support for this provision are identified in OPM Part Three, Chapter 5.

c. Nonavailability Statements (NASs)

MTF Commanders may give Health Care Finders written authorization to issue Nonavailability Statements (NASs) on their behalf, and the contractor shall perform these functions in accordance with DoD NAS requirements (See DoD Instruction 6015.23, as implemented by TRICARE/CHAMPUS Policy Manual, Chapter 11, Section 2.1. and OPM Part Two, Chapter 1, Section IV.G.). Such authorizations shall be by mutual consent of the contractor and the MTF commander. Specific policies and procedures shall be addressed in the MOU between the contractor and the MTF Commander. Health Care Finders shall coordinate all NAS requirements with MTF Health Benefits Advisors. (If the NAS issuance function is retained by MTF personnel, they shall coordinate the NAS issuance closely with the Health Care Finder in order to ensure that the appropriate clinical review is accomplished before issuing an NAS.)

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(1) For nonenrollees, after a determination is made that care cannot be provided in an MTF and prior to issuing an NAS, the contractor shall review the request to determine the medical necessity of the requested medical service. Requirements for determining clinical necessity are established in OPM Part Three, Chapter 1, Section II.A.1.c.

When authorized by the MTF Commanders, Health Care Finders shall consider the availability of services from MTF providers, in deciding whether to issue an NAS. If the care that is determined medically necessary is not available in the MTF, then an NAS will be issued. (See TRICARE/CHAMPUS Policy Manual, Chapter 11, Section 2.1 which contains DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities (MTFs)"; and OPM Part Two, Chapter 1, Section IV.G.)

(3) When the care is found to be medically necessary, but the beneficiary is denied an NAS because the care is available at an MTF, and the beneficiary is not satisfied with the decision, the beneficiary's only remedy is to seek an administrative review from the MTF commander in accordance with DoDI 6015.23.

d. Other Functions

The Health Care Finders shall inform beneficiaries of access mechanisms, referral procedures, and rules regarding use of providers. They shall also improve patient continuity of care by establishing mechanisms to facilitate necessary consultations, follow-up appointments, and the sharing of medical records (see OPM Part Three, Chapter 5).

2. Qualification of the Health Care Finders

Health Care Finders who perform the first level review functions as part of the authorization process for medical and surgical referrals shall be qualified physicians, registered nurses or physician assistants. In cases of mental health services, the contractor shall use licensed psychiatric nurses or other mental health professionals. Qualification requirements are further stated in OPM Part Three, Chapter 3, Section I.A.4. Health Care Finders who perform duties such as appointing and scheduling, that do not require clinical judgment, may have administrative or clerical qualifications.

B. Specialty and Inpatient Care

In each catchment area, the MTF is the first choice provider for all nonemergency specialty and inpatient care for the TRICARE program unless otherwise indicated by the MTF Commander. The contractor is responsible for coordinating the referral function for both beneficiaries and network providers through administration of a Health Care Finder program (Section II.A. of this section). If services are not available at the MTF, the beneficiary shall be referred to the contractor's network through Health Care Finders. If the required care is not available in the network, the health care finder shall arrange for care through a nonnetwork provider. The contractor shall ensure that all specialty and *inpatient* care for enrollees, whether provided in the MTF or in the civilian network, has been authorized.

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C. Specialized Treatment Services (STSs)

The Assistant Secretary of Defense for Health Affairs [ASD(HA)] designates Specialized Treatment Service (STS) facilities. These facilities shall be considered the preferred facilities for all MHS beneficiaries for the particular speciality services offered. These facilities take precedence for specialty care referrals for all TRICARE patients to the extent that they are available (see OPM Part Two, Chapter 24).

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beneficiary shall be required to pay only those installments required to cover the period of eligibility.

NOTE:

Contractors shall reimburse the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees (and their families) who have been recalled to active duty. Contractors shall calculate the reimbursement using monthly pro-rating as defined in OPM Part Two, Chapter 11. If the reactivated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its primary care manager, if possible (see TRICARE/CHAMPUS Policy Manual, Chapter 12, Section 7.1). Any enrollment year catastrophic cap accumulations shall be applied to the new enrollment period.

7. The contractor shall include full and complete information about the effects of changes in eligibility and rank in all beneficiary education materials and briefings.

G. Enrollment Portability

NOTE:

In some Managed Care Regions, the Lead Agent is responsible for administering enrollment portability provisions. Wherever the term "contractor" is used in this section, the term "lead agent" may be substituted where appropriate. The term "contractor" applies to Uniformed Services Family Health Plan (USFHP) designated providers as well as to MCS contractors. The following enrollment portability provisions apply to transfers involving the USFHP.

TRICARE Prime enrollees retain Prime coverage when they move or travel within an area served by the same contractor or when they move or travel to an area served by a different contractor. Enrollment portability provisions apply to TRICARE Prime enrollees' travel and location changes to and from all areas, including CONUS, Europe, South America, Pacific, Tidewater, Alaska, etc. The contractor for the region in which the beneficiary is enrolled on DEERS is responsible for providing continuing coverage and maintaining catastrophic cap accumulations for the enrollee while the enrollee is traveling or relocating. TRICARE Prime USFHP enrollees who are not CHAMPUS-eligible may only transfer enrollment from one USFHP designated provider to another USFHP designated provider; they may not transfer to an MCS contractor.

- 1. A Prime enrollee may transfer enrollment (OPM Part Two, Chapter 11, Definitions) after moving (temporarily or permanently) to a new location. A CHAMPUS-eligible Prime enrollee who is not relocating may either transfer enrollment from an MCS contractor to a USFHP designated provider or from a USFHP designated provider to an MCS contractor only once during an enrollment period, but may not transfer back to the other plan during that enrollment period.
- **2.** A contractor shall continue to provide health care coverage until the enrollee transfers enrollment to the contractor for the new location, the beneficiary disenrolls, or the beneficiary is disenrolled due to failure to pay required enrollment fees—whichever occurs first. Referral and authorization rules will continue to apply. PCM referrals

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are required only for non-emergency specialty or inpatient care (see 32 CFR 199.17). Claims for non-emergency care without an authorization shall be processed under the Point Of Service option (see TRICARE/CHAMPUS Policy Manual, Chapter 12, Section 10.1). In no circumstance will retroactive disenrollment be allowed in order to avoid Point of Service cost-sharing provisions. Even though a Prime enrollee who is relocating must request an authorization for nonemergency care from the losing contractor's HCF, the enrollee shall not be required to use a network provider, and the contractor shall ensure that the relocating TRICARE Prime enrollee's copayment is applied correctly to claims for authorized care.

- **3.** The TRICARE Prime enrollee who is relocating to another contractor's region or service area (for USFHP designated providers) can transfer enrollment from the losing contractor to the gaining contractor by contacting the gaining contractor during a base's "newcomer orientation," by using the contractor's 800 number, or by visiting the TRICARE Service Center or USFHP. During the initial contact, the gaining contractor shall provide region/site specific educational materials, key telephone numbers, the opportunity to select a new primary care manager, and the opportunity to disenroll completely from TRICARE Prime with no penalty for early disenrollment. If the enrollee chooses disenrollment, the gaining contractor shall notify the losing contractor, and the losing contractor shall update DEERS to reflect the disenrollment.
- **4.** On the day the gaining contractor receives a TRICARE Prime beneficiary's signed enrollment application agreeing to a transfer of enrollment to the new region, the beneficiary shall be considered enrolled at the new location and should contact the new PCM, the new region's Health Care Finder, or the USFHP for health care and health related assistance.

NOTE:

The effective date for transfer of enrollment differs from the effective date for initial enrollment. See this section, paragraph D.7. for information on initial enrollment in TRICARE Prime.

- enrollment application indicating a transfer of enrollment location, the gaining contractor shall, by written/electronic form, provide the losing contractor with the effective date of enrollment in the new region and ask the losing contractor for the following information: the enrollment anniversary date, the names of enrolled family members, the amount of the enrollment year catastrophic cap accumulation, and, if applicable, the enrollment fee payment option, amount paid, the due date of the next quarterly installment, information about any previous enrollment transfers, and any other information necessary to process the transfer to completion. After receiving a request for enrollment information, the losing contractor has four (4) working days to (a) disenroll the beneficiary on DEERS effective the day before the gaining contractor's effective enrollment date and (b) send the gaining contractor a written/electronic record of the required TRICARE Prime transfer information and notice of DEERS disenrollment. The gaining contractor shall enter the enrollment transfer information into DEERS and CHCS MCP (or the contractor's system) within four (4) working days of receipt.
- **6.** Enrollees in *the following* categories <u>who are relocating</u> to an area served by a different contractor shall be allowed two "out-of-contract" enrollment transfers (refer to OPM Part Two, Chapter 11, Definitions) per enrollment year if the second transfer is

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back to the first contract area of enrollment for the enrollment year: (1) TRICARE Prime enrollees in beneficiary categories required to pay enrollment fees (e.g., retirees, retiree family members, etc.) and (2) TRICARE/Medicare eligible enrollees who are not active duty family members. "Within-contract" enrollment transfers are not limited. When TRICARE Prime enrollment changes from one contractor to another prior to the annual renewal for enrollees in beneficiary categories required to pay enrollment fees, future unpaid enrollment fees, such as those paid on a quarterly basis, will be due the gaining contractor. There will be no transfer of funds between contractors, and, if the enrollee relocates to an area where TRICARE Prime is not offered, there shall be no refund of the unused portion of the enrollment fee.

Note:

Effective March 26, 1998, the enrollment fee is waived for those beneficiaries who are eligible for Medicare on the basis of disability or end stage renal disease and who maintain enrollment in Part B of Medicare.

H. Split Enrollment

NOTE:

In some Managed Care Regions, the Lead Agent is responsible for administering split enrollment provisions. Wherever the term "contractor" is used in this section, the term "lead agent" may be applied where appropriate. The term "contractor" also applies to a Uniformed Services Family Health Plan (USFHP) designated provider. Split enrollment provisions apply only to USFHP enrollees who are CHAMPUS-eligible.

Split enrollment involves different members of the same family enrolled with different TRICARE contractors (MCS contractors/Lead Agents/USFHP designated providers), e.g., the sponsor and spouse live and are enrolled in Prime in TRICARE MCS Region 7 and a college age child lives and is enrolled in Prime in Alaska; or it may involve one or more CHAMPUS-eligible USFHP enrollees and other members of the same family enrolled with one or more MCS contractors. "Split enrollment" provisions apply to TRICARE Prime enrollments in all areas, including CONUS, Europe, South America, Pacific, Tidewater, Alaska, etc. Until the implementation of a national enrollment year catastrophic cap file similar to the Central Deductible and Catastrophic Cap File (CDCF), each contractor shall maintain and track enrollment fees, copayments, and other TRICARE enrollee information for the family members enrolled in its own area. If contractors are notified that the catastrophic cap has been met or exceeded or that more than two family members are enrolled, contractors shall follow the procedures in TRICARE/CHAMPUS Policy Manual, Chapter 12, Section 7.3, paragraph F., to change the enrollment status from single to family enrollment with the same enrollment anniversary for all family members. All catastrophic cap accumulations shall be applied to the new enrollment period.

1. Active duty family members have no annual enrollment fee and each may enroll with the contractor providing care in his or her area.

For retirees, their family members, and other enrollees in beneficiary categories required to pay enrollment fees, a family will pay enrollment fees totaling no more than the TRICARE Prime family enrollment fee regardless of the enrollment locations of family members. If the family enrollment fee is not paid on time and the family is disenrolled, individual family members who are enrolled in different regions (and who have

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not paid single enrollment fees) shall be disenrolled as well. Such disenrolled individuals (previously not required to pay enrollment fees) shall be offered the opportunity to enroll in Prime in their own areas with no penalty.

- 2. Until the Department of Defense establishes the national enrollment year catastrophic cap file, contractors shall notify enrollees who have family members enrolled with different contractors that the family must monitor combined enrollment year catastrophic cap accumulations since the enrollment year catastrophic cap accumulations are maintained separately by each contractor. Someone must notify one of the contractors that the family's combined accumulations have met or exceeded the enrollment year catastrophic cap. The first contractor notified shall be the "lead" contractor for the purposes of verifying accumulations and notifying other affected contractors. When combined enrollment year catastrophic cap accumulations meet the enrollment year catastrophic cap, then no enrolled family member, regardless of enrollment region, shall be required to pay TRICARE Prime enrollment fees or copayments for the remainder of the enrollment year.
- **3.** The lead contractor shall request verification of family member enrollment year catastrophic cap accumulations from the other affected contractors within four (4) working days of notification that the catastrophic cap has been met (e.g., claims recapitulations). The other affected contractors shall provide requested information regarding catastrophic cap accumulations to the lead contractor within four (4) working days of the request. The lead contractor shall verify accumulations, and, if the cap has been met/exceeded, the lead contractor shall notify the other affected contractors within three working days that the family member(s) enrolled within the other contractors' regions are no longer required to pay Prime copayments or enrollment fees for the remainder of the enrollment year. The lead contractor shall also provide all necessary information (e.g., copies of claims recapitulations from all contractors involved) so that contractor(s) may determine if overpayments have been made. The appropriate contractor(s) shall refund overpayments to the enrollee(s) who made the overpayment(s).
- **4.** Contractors shall continue to maintain and monitor Fiscal Year catastrophic cap accumulations for enrolled and nonenrolled families as required in TRICARE/CHAMPUS Policy Manual, Chapter 13, Section 14.1 As with nonenrolled beneficiaries, once the Fiscal Year cap has been met for an enrolled individual or family, the contractor shall ensure that beneficiaries pay no more Prime copayments or other applicable out-of-pocket expenses for the rest of the Fiscal Year.

I. Disenrollment

- 1. All enrollees shall have the opportunity to disenroll during the annual re-enrollment period which occurs after twelve (12) months of continuous enrollment. Enrollees may disenroll when they move without a twelve (12) month lockout period. Any move, either within or outside the contract area, qualifies.
- **2.** If an enrollee who is not moving and who has not completed 12 months of continuous enrollment requests disenrollment, MTF Commanders (for catchment area residents) shall approve such requests on a case-by-case basis. MTF Commanders or, when applicable, the Lead Agent, will coordinate a request for early disenrollment with the contractor to assure disenrollment is effective on DEERS. The contractor shall maintain a log of the reasons for disenrollment and provide the information to the Lead Agent. There shall be no refunds of paid enrollment fees (with one exception, see paragraph F.6. above):

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however, the enrollee is not obligated to pay the remaining quarterly fees. Beneficiaries who have not moved and who disenroll from TRICARE Prime before the enrollment anniversary (with the exception of retirees who are recalled to active duty and their family members) and beneficiaries who are disenrolled because of failure to pay enrollment fees shall not be eligible for reenrollment for twelve (12) months.

